Issue 4 February 2003

network

SMMGP SUBSTANCE MISUSE MANAGEMENT IN GENERAL PRACTICE

A national newsletter on substance misuse management in primary care

Titration: can we make it work in practice?

Authors: Mark Gabbay, Tom Carnwath, Chris Ford, Kim Wolff

Backround - Before the launch of the 1999 Clinical Guidelines[1] few practitioners formally titrated methadone dose at treatment initiation. **Many services, particularly those in general practice still find the titration procedure* outlined in the guidelines difficult to organise** (*initial dose 10-40 mg, daily review for first few days, maximum increments of 10mg per day and 30mg per week). We wish to stimulate debate around this issue, in terms of the underlying evidence, resource implications, and relative impact compared to other harm and drug related death reduction strategies.

Research findings - Whilst the evidence is that methadone overdoses commonly involve other drugs and/or alcohol as well, **methadone is potentially lethal to naive adults users at doses over 20 mgs** [2, 3]. Additionally **it usually takes 4-5 days for methadone tissue and plasma levels to stabilise after dose commencement**, though accumulation continues beyond this to reach a steady state by 10 days [4, 5]. **A variety of factors can alter methadone plasma levels** including gastric emptying, pregnancy and liver metabolism (affected by disease and drug interactions). **These factors can increase the risk of overdose during the early phases of treatment**. The Australian National Drug Strategy documents adopt approaches which reflect these concerns[2].

Practice - **Many practitioners aim to increase doses, particularly for known, long-term, relatively high-dose users (1gram or more) quite rapidly, to stabilise between 60-120 mg. The aim of higher doses is to limit illicit drug use** once maintenance is established or prior to initiating methadone detoxification treatment. **For those with less established histories or habits, a more cautious dose titration is usually advocated**. We need to be confident though that the best available evidence supports pragmatic approaches to titration. An approach that compromises between available evidence and practical considerations is needed.

A current common **'compromise' practice of starting at 20-30 mgs of methadone and reviewing later that day or later in the week** aims to address dose stabilisation issues and the risk to naive users. However **the scientific evidence would suggest that a series of further assessments should be made within the first few days** to judge the cumulative dosing effects. **Few general practices currently have the resources to arrange this**, and implications include a restriction of dose initiation appointments to Mondays, a traditionally busy time, or only prescribing for patients once stabilised elsewhere.

It is quite common and acknowledged that illicit drug use (opiates) may continue during the early stages of treatment. Facilitation of accurate assessment may rely on patient co-operation in refraining from other illicit drugs. Whilst a low starting dose may reduce the immediate risk of

continued overleaf

Network

IN THIS ISSUE

www.smmgp.co.uk

continued from page 1

overdose among relatively naive users, it may limit the potential for opiate replacement to restrict or stop illicit use. **The accepted dangers of prescribing higher doses at the onset relate to the unknowns around patient history and methadone tolerance**, especially where additional support or monitoring are not possible, such as in primary care settings. Similarly **high dose heroin use, where methadone has not been used before or recently, does not equate with tolerance to methadone**.

Nevertheless **we do not know whether low starting doses could in turn thus raise cumulative opiate use**, the risk of pharmacodynamic interactions from poly-drug use, and hence risk of accidental overdosing. In Australia 90% of those who die during stabilisation are also using other toxic drugs, in particular benzodiazepines, alcohol and heroin. The Australian documents (*Humeniuk et al) 2000* admit that there is no evidence to exclude the possibility that this cautious approach might paradoxically increase the risk of fatal overdose.

The original basis for methadone maintenance was blockading opiate receptors using high doses. **Little is known about the relative behaviour change impact of cautious versus receptor blocking dose induction, although in the longer-term, evidence suggests that doses of at least 50 mg methadone per day are more effective.** There is evidence against rapid high dose induction, although the picture may not yet be complete, but research is urgently required into the patterns of drug use after methadone induction.

Balancing act

- it is clear that **primary care based treatment services are necessarily going to provide much of the routine interventions** for substance misuse in the UK. **It is less clear how general practice can realistically deliver titrated dose induction**. The evidence would suggest that best practice would indicate that once objective evidence confirmed opiate use (e.g. urine test, signs of injecting, and/or withdrawal), the effect of a supervised consumption of the starting dose would be made a few hours later, and then probably daily for the next four to five days until it can be reliably assumed that a steady dose has been attained. At this point it may be appropriate to consider adjusting the dose upwards if required, tailored according to withdrawal symptoms.

Whilst **supervised consumption should reduce uncertainty about the fate of prescribed opiates, it is less clear how we account for illicit use.** Results from urine drug screens often take a week or more, and clinicians largely rely on self-report, background knowledge and physical examination to inform dosing decisions in such circumstances. Regular review during the induction phase facilitates the reinforcement of education about the risks of continuing to use alcohol and illicit drugs once on methadone, and presents opportunities for further assessment and interventions.

The intensity of such a review service lies beyond that practically provided within primary care settings as currently resourced. It is also **doubtful that most specialist services have the capacity to assess and titrate all newly presenting clients currently seen in primary care**, and would need considerable additional investment or reductions in other aspects of their service to do so. Such a solution may reduce access and become a rate-limiting step for service delivery for new clients, and reduce capacity to deliver care to complex clients and those referred from primary care and elsewhere.

Community **pharmacists providing supervised consumption could perhaps provide a titration service.** Collaborations between specialist and primary care services and pharmacies are developed in some parts of the UK. **However, the practicalities of dose adjustment, and requirements for training, time and physical space may preclude widespread take-up within the retail sector**. **Allowing specialist nurses to prescribe controlled drugs may be a better solution**, or at least clarifying arrangements whereby they might adjust doses within a range predetermined by the medical prescriber.

As fatal overdoses are rare, a large, longitudinal, prospective multi-centre trial would be required to provide evidence on the most appropriate method of titration and induction. In the meantime **best available evidence suggests that long-term, high dose relatively tolerant users need fairly rapid inductions to relatively high levels. Newer, younger and less tolerant users will require a more cautious approach, probably within a specialist setting**. The middle group remain a particular dilemma, but can probably have their dose initiated and titrated within primary/shared care settings.

Future directions

- An evidence gap exists around titration procedures and risks associated with dose initiation. This is reflected by a variety of practices, some of which attempt pragmatic interpretation of recommended best practice. Little is known about the effectiveness and relative risk reduction value of these practices. **Are we confident that the evidence to date justifies the resource allocation required to provide daily dose titration, which is recommended as best practice?** This is likely to use up much of the available investment in reducing drug related deaths, reducing the potential to intervene in other areas of prevention.

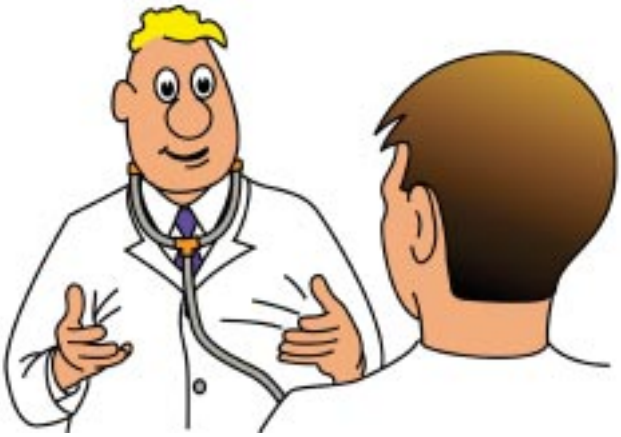
We cannot control a host of other factors influencing risk during methadone induction. We should be confident that pragmatic titration practices do not increase risk e.g. cautious titration encouraging illicit use due to inadequate blockading. **We should not delude ourselves that titration alone is sufficient to prevent overdoses.**

Evidence suggests that the risk of death among users out of treatment substantially exceeds that during the induction phase. **Investment into titration may reduce access overall, particularly for the chaotic users most at risk**, and reduce resources for counselling, relapse prevention, detoxification or community initiatives. **We need debate**, and evidence that can be confidently applied to the UK situation, that can inform it. Perhaps readers can **start by using the SMMGP web pages as a forum for discussion on these issues.**

1. Department of Health. Drug misuse and dependence - guidelines on clinical management. 1999. London, Stationery Office.
2. Humeniuck, R., Ali, R., White, J., Hall, W., & Farrell, M. Induction and stabilisation of patients onto methadone: evidence based guidelines. [39]. 2000. Canberra, Commonwealth Department of Health and Aged Care.
3. Milroy, C. M. & Forrest, A. R. W. 2000, "Methadone deaths: a toxicological analysis", *Journal of Clinical Pathology*, vol.53, pp. 277-281.
4. Wolff K, Rostami-Hodjegan A, Hay AWM, Raistrick, Calvert R, Tucker GT (2000). A drug prediction technique for methadone treatment. Addiction 95, 124-131.
5. Rostami-Hodjegan A, Wolff K, Hay AWM, Raistrick D, Calvert R, Tucker GT. (1999) Population pharmacokinetics in opiate users: characterisation of time-dependent changes. *British Journal of Clinical Pharmacology*, 47, 974-986.

Alcohol –

What would be the ideal clinical care for a patient entering a community alcohol detox facility?



Alcohol overuse presents a huge burden on the National Health Service. Over 28,000 hospital admissions due to alcohol dependence or toxic effects occur each year[1]. Alcohol misuse causes 30,000 deaths a year[1].

A key ethos for a community alcohol detox unit is whether its objectives are to achieve **life long abstinence for those who enter the unit, or respite from the debilitating condition of alcohol dependence**. In my view both are reasonable objectives. However **a unit would need to be explicit about its objectives** so that all parties could work towards an agreed treatment plan. Another key ethos of a unit would be whether it admits patients in crisis or once pre-detox work had been completed. My view is that **it would be both more time and cost effective if patients had undergone some pre-detox work prior to admission**. This would include looking at and addressing triggers for alcohol dependence. It would also involve planning to see detoxification as a wider goal of addressing issues such as housing, social networks, employment, hobbies and steps taken to prevent relapse.

Once admitted to the unit the patient would need to undergo a thorough **health assessment**. Such an assessment would include a history of alcohol intake, when the patient last consumed alcohol and previous attempts at detoxification. A thorough **medical history** would also need to be taken as alcohol dependence can cause the following physical conditions: gastritis, peptic ulceration, oesophageal varices, carcinoma of the oesophagus, carcinoma of the oropharynx, alcoholic cirrhosis, pancreatitis, hepatitis, peripheral neuropathy, epileptic seizures, Wernicke's encephalopathy (though note this is rare, more common is memory impairment whereby recent memory is impaired, immediate memory is preserved, learned behaviour is preserved but the patient does not know they have a problem[2]), Korsakoff's psychosis, cardiomyopathy, vitamin deficiency (especially thiamine), obesity, foetal alcohol syndrome in the case of a pregnant alcohol user, alcoholic hallucinations, depression or sexual dysfunction.

It would also be important to take a **social history**, which would include employment, whether the patient lived alone or with family or friends, and whether such social contacts were supportive of the patient undergoing detoxification. Finally a history of current medication and allergies, in particular any medication that was toxic on the liver would need to be noted.

A **physical examination** (to exclude any of the conditions listed above) and including the patient's pulse rate and blood pressure would need to be taken prior to detoxification, and withdrawal symptoms would need to be monitored via a severity of withdrawal scale. This would enable titration of the dose of chlordiazepoxide to be done against the withdrawal symptoms. **Chlordiazepoxide** *(Librium)* should be used and *chlormethiazole (Hemineverin)* ***never*** *used* as chlordiazepoxide is both less toxic in overdose, having less effect on the respiratory system, and has a lower addictive potential . A suitable **second line treatment could be diazepam** (5mg of diazepam equates to 15mg of chlordiazepoxide[3]). Additionally vitamin supplementation (e.g. thiamine 100mg tds) can be given routinely. **Blood tests** are worth doing routinely to check for liver damage. These could include full blood count, U/Es and LFTs. A full blood count could show evidence of a macrocytic anaemia and a low platelet count. LFTs could show high liver enzymes, particularly ALT (evidence of liver damage) and a low albumin and total protein (evidence of poor liver function).

The patient would also benefit from **supportive counselling** to help prevent relapse. The effectiveness of such counselling would be increased if the patient also agreed to take a **pharmacological intervention to prevent relapse, either disulfiram or acamprosate**. However these medications have been shown to reduce the mean number of drinking days post detoxification, but not to successfully prevent relapse[4]. However prescribed as a treatment for respite to reduce the number of drinking days can be a valid intervention[5].

In summary, the clinical care of alcohol withdrawal includes thorough assessment, attention to both the physical withdrawal symptoms and the health complications of alcohol overuse and a focus on relapse prevention.

Dr Nat Wright - NFA Health Centre for Homeless People, 68 York Street, Leeds, LS9 8AA. Tel: 0113 295 4840

References

[1] Alcohol Concern *Your very good health?* Alcohol Concern, London 2002.

[2] Jackson, M. Alcohol Related Brain Damage: current state of affairs. Conference speech: Australian Professional Society of Alcohol and other Drugs, Adelaide, 2002.

[3] British Medical Association/Royal Pharmaceutical Society of Great Britain *British National Formulary 44*: London 2002.

[4] Consumers Association. Managing the Heavy Drinker in Primary Care. *Drugs and Therapeutics Bulletin*, 2000; **38(8)**: 60-64.

[5] Heather, N Disulfiram treatment for alcoholism: deserves re-examination, *British Medical Journal*; **299**: 471-472

Seivewright, N. *Community treatment of drug misuse: more than methadone.* Cambridge University Press: Wiltshire 2000.

GPs can't do everything–

Why I don't do it

Dr Gillian Braunold is a GP in 'inner city' Brent

I am a GP in Kilburn which is an inner-city practice in which the patients have problems with alcohol and substance misuse as well as a very high level of pathology in a multicultural, multiracial society where white, English speaking citizens are the minority.

We have 6500 patients in a crowded Victorian building where there is a great deal of pressure for space in the building, partners, registrars, nurses and associated attached staff having to share consultation rooms and we have to timetable rooms for staff carefully.

We offer CAB, smoking cessation and health visitor space within the surgery. A local St Mungo's hostel's 30 residents are registered with us. All our patients receive equal access to all of our services and we offer harm minimisation to our addicted patients.

I believe passionately that we as GPs can't do everything and we have to choose which areas of our professional life we wish to develop. There are many conflicting demands on our capacity to develop and our patients need to have access to the totality of services available within the health service. **Within our practice we have one GP with special interest in dermatology**. We are a training practice and have refugee doctors spending time with us on their vocational training scheme.

In order to provide a quality substance misuse service not only would we as clinicians have to spend a great deal of time on this service and learn the necessary skills; but our reception staff would need to have extra training and we would need to put extra administrative systems in place. This is an extra demand on our staff which we have chosen not to make. In contrast they have been well trained in the needs of a population who don't speak English as a first language and the assessment of the needs of refugees.

We believe that the work required is that of a GP specially trained in that area and that is why it deserves the extra funding to resource the service.

We do expect however our patients to have access to a quality service locally funded by the PCT. This needs to be readily accessible by us, and the patients of the locality, **in the same way as family planning services are offered for patients whose GP practice doesn't offer the same range of service**. The service needs to be manned by the clinicians with the expertise to offer the service. **These clinicians may well be the GPs from the locality who wish to offer the service from a dedicated clinic where the necessary infrastructure skills have been acquired by the administrative staff**. There should be space in that setting to provide the counselling and other associated skilled drug workers that we can't physically accommodate.

A first class service requires an integrated approach that caters for all the types of practices in the area and therefore the patients within them. **The world of the New GP Contract recognises the necessary limitations on aspirations made of GP practices and enables the partnership between the PCT and the practices to ensure that quality primary care services of a specialist nature are available to all the patients of the area.**

A generalist by character and inclination -

Why I do it

Dr Rory Newman is a GP in rural North Yorkshire

I am a GP partner in a 2.5 principal dispensing practice in rural North Yorkshire. **I enrolled for the RCGP certificate course in the management of drug addiction** because the subject interested me, and it was something I was already doing without much training. The course was helpful and supportive, and has left me with more confidence in this potentially difficult and controversial field.

At the recent post-course RCGP conference there was considerable discussion of the GP with Special Clinical Interest (GPSI) idea. **Some of the great and good seemed to expect the certificate to lead on to GPSI status for GPs, and there was surprise that more of us were not following this path**. However, the discussion convinced me that I did not want to be a GPSI.

The GPSI model suggests working 3 or 4 sessions a week. This does not easily fit me, my practice, or my locality. **I am a generalist by character and inclination, with a number of interests: I do not wish to pursue one interest to the exclusion of others**.

My practice is too small to lose 3 to 4 sessions regularly; we would need to find and employ an extra half-time partner. There would still be problems around holidays and sickness absence; locums are often not available locally. Our absolute maximum would be one GPSI session a week, and only if I could work at the surgery.

This is a locality without large population centres, supporting only 20 GPs. **To justify the proposed sessions, a GPSI would have to see most or all of the locality's drug-related problems. This would potentially de-skill other GPs** (I see this as a potential pitfall with the whole GPSI concept). A service which depended on one GPSI would not operate while that GP was away, and would collapse if they resigned/retired.

There is a potential for ghettoising addiction services and their users: I see the value of real specialists for difficult situations but **addiction is so common a problem that its treatment should be the norm for ordinary GPs, not an esoteric preserve of the few**.

I think there is a good case for having GPSIs at the next tier up to provide specialist advice for a PCT area, on service planning and commissioning as well as in difficult cases - but I ain't volunteering! My practice currently provides an addictions service which it costs us to maintain; it would be nice to be paid for this - **but I would rather stay as a GP with an interest in a speciality, not a GPSI.**

Classics revisited

Street Drugs - The Facts Explained, The Myths Exploded

Andrew Tyler, 3rd edition published by Hodder and Stoughton (1995)

If you are a parent, teacher, drug user, or health professional you will find Andrew Tyler's Street Drugs an excellent read. Tyler explores the political and historical background of each drug and examines the style and mode of their use.

The mental and physical effects of substances are described in a language that non-medics can understand, but if you are excited by blood and gore you may be disappointed. He offers self-aid tips and guides us through the law and trafficking trends. He provides a list of support groups, agencies and clinics, but sadly these are now out of date.

Linking drugs to politics he mentions how the demand for an increasing variety of drugs is attributed to the leap into an uncertain technochip future, an indication that more people are seeking to obliterate the meaningless of their lives. The great pity, he says is that society lacks the maturity to handle these new drugs.

But is it more then just coincidence that in the 1985 preface he calls for the creation of a range of properly funded services that don't necessarily focus on abstinence as the overall goal? He argues that the disproportionate power in the hands of psychiatrists to decide and manage 'treatment' should be reconsidered and a share of the pot should go to street agencies, housing, education, job training and health care. Was he a pre-NTA visionary? So where are you now Andrew Tyler? Many may feel that your book is out dated. Is it time to revisit this modern classic?

Chris McArthur

Re-launch of the drug strategy

The continuing centrality of treatment to the drug strategy was emphasised in the updated strategy which highlights a key role for primary care in looking after drug user's health, irrespective of their prescribing needs. The strategy also contained a 3-page summary of the national crack strategy. The updated strategy is available on line at http://www.drugs.gov.uk/ReportsandPublications. Hard copies are available at NTA head office or on request from homeoffice@prolog.uk.com

Implications for primary care in next edition

Paper review

Robles E., et al., Implementation of a clinic policy of client-regulated methadone dosing.

Journal of Substance Abuse Treatment:2001, 20. Pages 225-230.

This study undertaken in the US allowed patients to decide their own dose of methadone. Anti-diversion mechanisms were kept in place. Half the caseload had been in treatment for at least 6 months and for 16 months after. Urines positive for opiates dropped from 5.3% to 1.6%, discharge and retention rates were unaffected and no methadone diversion was recorded. The average dose increased only slightly from 77mgs to 80mgs; nearly 90% were on doses of 100mgs or less and only one patient increased their dose to 300mgs with no evidence of diversion.

Previous studies have also shown that patient self-regulation of dose leads to better outcomes than doctor-regulated inflexible regimes or regimes with a bias towards minimising doses. Allowing patients to set their doses does not lead to excessive doses, retention and outcomes do not suffer, illicit opiate use is reduced and patient satisfaction and client-staff relations may improve. As long as measures are in place to minimise overdose risk and prevent diversion, allowing stabilised patients to regulate their doses removes a source of friction and improves outcomes compared to less flexible regimes. Introducing such a flexible regime into some UK treatment centres may certainly improve outcomes.

Beich A., Gannik D., Malteraud K., Screening and brief intervention for excessive alcohol use: a qualitative interview study of the experiences of general practitioners.

BMJ: 19th October 2002, 325. Pages 870- 872.

This was a qualitative study interviewing GPs (in Denmark) who had participated in a study of a combined programme of screening and a brief intervention for excessive alcohol use. 24 GPs took part and were surprised at how difficult it was to establish rapport with the patients who had a positive result on the screening and to ensure compliance with the intervention.

A programme of screening for excessive drinking followed by a brief intervention is officially recommended as a prevention strategy in primary care, but implementation of such programmes has been a problem. The interviewed GPs found the programme disruptive of working arrangements and found it difficult to establish rapport with excessive drinkers and to ensure their compliance with the intervention. The BMJ comments that the results underline the value of context specific, pragmatic studies to evaluate the suitability of seemingly efficacious programmes.

Amphetamine

Usage - Amphetamine is used by huge numbers of individuals in the UK and elsewhere, and is often viewed as being part of the "recreational" drug scene, along with ecstasy, LSD, magic mushrooms etc. A common way of taking it is to wrap some of the powder in a cigarette paper and swallow it ("bombing"), while others put it in drinks or "dab" some on a finger, or snort or inject it. Most use in recent times has been of the very impure street powder preparation known as "speed", "whizz" or "phet", but the putty-like "base" substance is increasingly popular and is more potent, as is "ice". The latter can broadly be thought of as the crack cocaine of amphetamine, but at present it is not commonly seen here. Street powdered amphetamine is a racemic mixture of the dextro- and levo-forms of the drug, the latter being largely inactive.

A proportion of amphetamine users become extremely committed and progress to heavy and even daily use. A characteristic pattern in a moderately committed user would be to have the drug for two days and nights in a row going without sleep or much food, and then to stop for about the same period. Often it is the mood disturbance or paranoid experiences which limit usage, but some individuals almost seem to overcome these and use very large amounts, e.g. 7 g (a quarter of an ounce) per day. Most problematic of all is heavy usage by injection, when individuals can seem clearly dependent in general terms.

Clinical problems - Mood disturbances are very common, especially depression on "coming down", and nearly all doctors know that heavy usage can lead to a drug-induced psychosis virtually indistinguishable from acute schizophrenia. The drug is a stimulant and like cocaine can lead to cardiovascular problems through the effect on noradrenalin, including ultimately heart attacks or strokes. If users inject, the whole range of complications of that aspect can occur including blood-borne viruses, and some "dependent" users can become extremely ill through direct drug effects and the consequences of very frequent injecting. Weight loss is characteristic, and unfortunately is often a desired effect in the early stages.

Treatment - In the vast majority of cases of amphetamine misuse the only advisable treatment is systematic drug counselling, aimed at helping the user reduce or stop their drug through behaviourally based tactics. Much though we like to see the benefits of both substitute and non-substitute prescribing in opiate misusers, we must be quite clear that medical approaches have hardly any role in stimulant misuse. This is not a matter of principle, but it is simply that no medications have been shown to be of definite efficacy (and in cocaine misuse over a hundred different compounds have been tried in studies!). Sometimes antidepressants and tranquillisers can be given in carefully controlled withdrawal attempts, but there is a great danger of the latter simply being used as an ongoing aid to "coming down". Some specialists make a parallel between the seemingly dependent injecting users and their counterparts using heroin, and believe that the substitute prescribing approach (i.e. dexamphetamine) can usefully be applied in selected cases. At present this method is seen as being outside the remit of management of users within mainstream primary care*. Finally, complications of amphetamine use such as psychosis can require direct treatment in their own right.

* **Editors Note:** The Department of Health Clinical Guidelines (pages 42-43) state that there is limited evidence for dexamphetamine prescribing and are cautious in supporting its use. They state that initiation of dexamphetamine prescribing should only be by specialists and specialised generalists with adequate experience in this technique.

Dr Nicholas Seivewright

Consultant Psychiatrist in Substance Misuse, Community Health Sheffield NHS Trust

Dr Seivewright has reviewed the practical management of amphetamine problems in more detail in his textbook *Community Treatment of Drug Misuse: More than Methadone* (Cambridge University Press, 2000)

Prenatal exposure to ecstasy and other recreational drugs – participants needed

The Development and Infancy Study (DAISY) is looking at whether the use of recreational drugs during pregnancy influences the behaviour and development of babies after they are born - drugs such as ecstasy, LSD, alcohol, cannabis, cocaine, nicotine or stimulants. We are interested in women who are currently pregnant and have used any of these drugs, including limited amounts, before or during pregnancy. Participants need to live within reasonable travelling distance of East London's Stratford Campus (£20 store voucher per visit). Further details, posters and A5 flyers call 020 8223 4587. Information treated with strictest confidence.

Dr Fixit

Working on amphetamine

Angie came to see me to ask for help. She had been registered since birth and her family was well known to the practice. She had been becoming increasingly tired in her job as a dental nurse and she had started to take illicit amphetamines. The amount she was using was increasing to at least 1 gm/day (costing £10-15 /day) and she now could not manage without taking them 2-3 times / day and could take them up to 6 times / day. She was buying them from a friend and taking them in juice (or coffee) mixed with glucose; she has never injected. She takes no other drugs, confirmed on urine testing x2, and only occasional alcohol. Her presenting problems other than tiredness were low mood and

insomnia. She had been warned at work because of frequent late arrivals. She is requesting prescribing help to be able to stop her habit. She had tried to stop herself on several occasions and has also had counselling but had not managed to stop. I am an experienced GP and work with several amphetamine users. I feel prescribing will help this woman – do you agree?

Response: Dr Chris Ford GP, and Dr Tom Carnwath, Consultant Psychiatrist in Addictions

You have started well. You seem to have a good therapeutic relationship, which will be helpful. **You have undertaken a full history including a drug and alcohol history and confirmed her drug use with urines**. Some laboratories provide a urine test distinguishing street from pharmaceutical amphetamine (although not many).

We would next ascertain if she has developed any complications of her drug use such as medical (hypertension, weight loss, dental problems), psychiatric (depression, anxiety, psychotic symptoms), social (loss of relationships), financial (how is she paying for her drugs?) and / or legal. **We also think it is always worth asking about an eating disorder in this type of patient.** Eating disorders are often associated with amphetamine use and without specific treatment, the amphetamine problem much harder to treat. It is important to establish her aims and her motivation to change and what the other external factors are, such as family, the threat of losing her job.

Next decide with her on a treatment plan. We would start with harm reduction, giving her good information about amphetamines and health risks and how to reduce them. Then refer her to the practice counsellor to work specifically on behavioural change using motivational interviewing techniques. If you don't have a counsellor in-house many community drug teams and street agencies can provide this help.

For many amphetamine users this approach is successful but for some and perhaps Angie, we would agree that she may need pharmacological treatment to help because she has previously failed with counselling alone.

Many drugs have been tried most with little to no success. Tricylic antidepressants, such as lofepramine have been tried but are probably more helpful in treating the underlying depression rather than as a substitute drug. Selective serotonin re-uptake inhibitors, such as fluoxetine should not be used alongside amphetamine, because of the small risk of a "serotonin syndrome" (footnote in Clinical Guidelines).

The only 'replacement' drug available in the UK is dexamphetamine sulphate and it has a limited place. (NB there is a long acting form of amphetamine available in the US and may be more helpful for people who are unable to stop in the same way that methadone is used as a long acting replacement for heroin users.) The evidence for dexamphetamine prescribing is pretty weak, particularly for oral users. For this reason a cautious approach with clear treatment aims and timescales is required. The evidence for reduction in injection frequency is probably the stronger. Further trials are under way at present.

As you have experience in prescribing for amphetamine users, we would advise you to consider putting Angie on a small reducing dose of dexamphetamine preferably after a full discussion with your local specialist service, or refer her to them for prescribing.

This reducing drug programme needs to be undertaken with motivational interviewing proceeding at the same time. We would titrate her to the lowest possible dose – probably between 25-35mgs (5mgs x 5 – 5mgs x 7), written on a FP10 MDA for daily dispensing. (NB Supervised consumption is difficult because of its short half-life and the need to split the doses.) We would then, working with the patient slowly reduce the amount down to nil, continuing to provide psychological support during and after the reduction.

In summary Angie needs regular psychological help with or without antidepressants and as she has failed to detox without prescribing help on more than one occasion, we would consider a reducing regime of dexamphetamine sulphate from yourself or the specialist drug team.

Dr Fixit
Pressure to prescribe

"A new patient came to see me last Friday saying he was using 1/2 gm of heroin IV daily. He was keen to stop and had not taken anything that day and wanted me to prescribe for him straightaway. He did not want to continue putting himself at risk. I explained that I needed to undertake an assessment and suggested he left a urine sample for testing and returned on Monday for a full assessment. He was happy with this and did return. Did I do the right thing? Should / could I have helped him as an emergency?"

Response: Dr Chris Ford GP, and Jean-Claude Barjolin

Yes you did the right thing, If you do not have time for a full assessment or if you feel *pressured* to prescribe, take a urine and conduct an initial consultation and **ask the patient to come back to complete a full assessment**.

This also allows you time to take advice, confirm any given patient history with other providers and arrange support for you and the patient. If you have little or no training, experience or support, it is best not to initiate prescribing at subsequent consultations but to seek a referral or support for the patient. Whilst substitute prescribing may be a *preferable early option*, do not be rushed into it without a proper assesment - this is how mistakes can happen.

Most patients in this situation have been obtaining and using drugs, and managing their drug use for some time. The patient needs to be listened to and know they will be given help as soon as possible but neither you nor they gain by not offering a **planned response**. Never initiate prescribing without confirming dependency – including a positive urine for morphine and / or methadone, and a full drug and alcohol history.

When you or a drug worker has completed the history and assessment you can then decide whether you are happy to begin prescribing or you would prefer the local service to prescribe in the initial stages. *Remember that prescribing is the particular responsibility of the doctor signing the prescription and you should only work up to your confidence and experience.* Set and review treatment goals with the patient and arrange for non-prescribing / therapeutic input for the patient if required. Notify the patient to the National Drug Treatment Monitoring System.

Bulletin Board

The most comprehensive directory of drug treatment services in England for five years, has been published by DrugScope with part funding by the National Treatment Agency. It is available at www.drugscope.org.uk/drugbaseii/home.asp and regularly updated. A licensing contract with DrugScope can provide regular access. For a copy priced at £20.00 please contact Marston Book Services on 01235 465500 (ask for direct sales) or e-mail direct.orders@marston.co.uk

London and Southeast Shared Care Workers Forum. This forum was established 2 years ago, to provide support for workers developing and managing shared care schemes. It now includes GP liaison workers and shared care co-ordinators in statutory and non-statutory services and primary care trusts. Members come from all over London and the surrounding counties. The forum meets four times a year in a central London restaurant, sponsored by Schering Plough, and has one guest speaker per session. The next meetings are on February 14th and May 9th. If interested in attending, contact Denise Isherwood on 020 8795 6173, email-denise.isherwood@brentpct.nhs.uk

'Myths of overdose' information and video are available on-line at the fantastic Exchange Safer Injecting website http://www.saferinjecting.org/campaignmaterials/odbrieftext.html or http://www.goingover.org.uk/. Overdose video on the site.

Guidance for PCTs - Improvement, expansion and reform (IER) is the Planning and Priorities Framework (PPF) that sets out the targets for NHS organisation for the next three years. These include targets on treatment for drug misuse. PCTs are required to submit local delivery plans to strategic health authorities, setting out how they meet these targets. The guidance has been mailed to all DATs, has been highlighted to treatment providers and is available on line at www.nta.nhs.uk/guidance/primarycare.htm

National Drug Treatment Monitoring System (NDTMS)
The NDTMS will be jointly managed by the NTA and the Department of Health from April 2003. A minimum data set will allow for the monitoring of drug treatment targets and key performance indicators. The intention is for this data set to be integrated into the patient recording systems of all providers of structured treatment services. An electronic messaging system will be implemented that automatically forwards the necessary data items from providers to commissioners and the regional database function, replacing the current paper based system.

Hot Topic - Section 8

Amendments have been made to Section 8 (d) of the Misuse of Drugs Act 1971 by section 38 of the Criminal Justice and Police Act 2001. This will bring the law 'up to date' by extending the scope of Section 8 (d) to make it an offence to allow on premises "administering or using a controlled drug which is unlawfully in any person's possession at or immediately before the time it is administered or used". Previously the legislation applied only to opium and cannabis.

Before implementation the government has produced guidelines intended to protect workers from falling foul of legislation. This guidance at present seems inadequate. The guidance says that legitimate harm reduction activities should be taken into consideration before a prosecution takes place but gives no exemptions. It also quite clearly implies that prosecution of professionals is appropriate in certain circumstances. The scope of the act has been widened without adequate safeguards being put in place, worrying for us all. The full guidance can be found at http://www.ixion.demon.co.uk/section8.htm

View Point

Home Office consultation on paraphernalia.

The Home Office proposals on drugs paraphernalia are flawed: http://www.drugs.gov.uk/News/1037623265

Currently Section 9A of the Misuse of Drugs Act 1971 makes it an offence to supply any article - except a syringe or needle - in cases where the supplier believes it may be used by the recipient to administer an unlawful drug or prepare an unlawful drug for administration. On the advice of the Advisory Council on the Misuse of Drugs (ACMD) the government proposes that the supply of sterile water ampoules, swabs, spoons, bowls and citric acid should now be lawful.

It is unclear what public interest is advanced by making the supply of any drug paraphernalia an offence. Good law prohibits specific acts that are against the public interest: 'blanket' prohibitions run into problems of interpretation as new products for drug preparation and administration emerge - for example, 'safer' crack smoking pipes that have recently been introduced in Canada. Paraphernalia laws are daft because many common products can be used for administering drugs - rubber tube for tourniquets and so on. The nonsense is that under the Misuse of Drugs Act it is unlawful to supply matches - on the basis that this aids drug misuse! (para 8 of the consultation). Furthermore, the law is selectively used (mainly as a threat against drugs projects and drugs workers). Have tobacconists been prosecuted for selling cigarette papers?

The basic premise of Section 9A was not questioned. The onus was put on ACMD (and others) to prove the harm reduction benefit of each product. I think we need to turn this on its head and challenge the government to prove that the supply of certain products (matches, razor blades, cigarette papers - or anything else that could be used to get drugs into the body) – is harmful. Section 9A is bad law and should be repealed in its entirety.

Gerry Stimson

Write to Naim Siddiqui at the Home Office, Organised Crime, Drugs and International Group, Communities and Law Enforcement, Drugs Unit Room 243 50, Queen Anne's Gate, London SW1H 9AT. Email Tony.Hall@homeoffice.gsi.gov.uk

'Viewpoint': If you feel you have something important to draw attention to, contact SMMGP.

NETWORK Production

Production Editor Jean-Claude Barjolin

Associate Editors Jim Barnard, Christina McArthur and Simon Morton

Advisory Editors Dr Chris Ford, Dr Clare Gerada

Contact Mark Birtwistle, Management Support Officer, SMMGP, c/o Trafford Substance Misuse Services, 1-3 Ashton Lane, Sale, Manchester, M33 6WT
Tel: 0161 905 8581, mark@smmgp2.demon.co.uk

www.smmgp.co.uk

NETWORK NEWSLETTER IS SPONSORED BY SCHERING-PLOUGH LTD

Network ISSN 1476-6302

SMMGP works in partnership with

1952-2002 Trafford Substance Misuse Services NHS National Treatment Agency for Substance Misuse

SMMGP is funded by the Treasury, Invest to Save Budget

ISB